NHS England's three year delivery plan for maternity and neonatal services

On 30 March 2023 NHS England published a three year delivery plan for maternity and neonatal services. Following several national plans and reports, including the reports by Donna Ockenden and Dr Bill Kirkup, the plan brings together the key objectives services are asked to deliver against over the next three years. This briefing summarises the key contents of the plan. If you have any comments or questions on this briefing or the plan, please contact NHS Providers policy advisor for quality, Matt Case (matt.case@nhsproviders.org).

Key points

Most women have a positive experience of NHS maternity and neonatal services, and the plan highlights that 900 more families now have a healthy baby each year compared to 2010. However, there have been many examples of poor care over many years, including as detailed in reports by Donna Ockenden and Dr Bill Kirkup, each of which made several recommendations to improve maternity safety.

NHS England has developed this new delivery plan in consultation with service users, healthcare staff, trust leaders and other stakeholders, as well as with the Independent Working Group on maternity chaired by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists (RCOG). This consultation has supported NHS England to triage and review the actions remaining from the Ockenden and Kirkup reports as well as existing NHS England plans for maternity.

The report sets out the 12 priority actions for trusts and systems for the next three years, across four themes:

- Listening to women and families with compassion
- Supporting the workforce
- Developing and sustaining a culture of safety
- Meeting and improving standards and structures

Below we set out more detail about the actions contained under each theme.

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Theme 1: Listening to and working with women and families with compassion

The plan identifies listening and responding to women and families as an essential component of safe and high-quality care: the importance of listening emerged strongly from both the Ockenden and Kirkup reports.

The first objective in this theme is for **all women to receive compassionate personalised care** based on an ongoing dialogue between women and families and their clinicians. The objective requires trusts to:

- Provide maternity and neonatal staff with time, training, tools and information to deliver personalised care
- Undertake regular audits of personalised care, including seeking feedback from women and parents, and acting on the findings
- Consider how to achieve midwifery continuity of carer in line with safe staffing principles
- Achieve the UNICEF UK Baby Friendly Initiative (BFI) standards on infant feeding, or equivalent, by 2027.

NHS England and ICBs also have actions under this objective, with NHS England in particular committing to actions including:

- Producing standardised information to support the delivery of personalised care and aid decision-making
- Extending the national support offer for services who haven't achieved UNICEF BFI accreditation or equivalent
- Creating a new patient-reported experience measure for maternity services by 2025.

The second objective is to **improve equity for mothers and babies** by addressing key health inequalities. This objective requires trusts to:

- Pay particular attention to health inequalities in providing services, for example facilitating informed decision-making in areas of inequalities and ensuring access to interpreter services
- Monitor differences in outcomes and experiences for women and babies from different backgrounds and make changes in response.

NHS England will in turn provide support for the implementation of Local Maternity and Neonatal System equity plans and pilot and evaluate new service models designed to reduce inequalities.

Objective three calls for trusts to involve service users in quality, governance and co-production when designing and planning delivery of maternity and neonatal services.

NHS England will use indicators from the CQC's maternity survey to monitor progress against this theme, as well as some indicators from services including whether perinatal mental health services are in place and the proportion of services achieving UNICEF BFI accreditation.

Theme 2: Workforce

NHS England's report acknowledges that the ambitions of the plan "can only be delivered by skilled teams with sufficient capacity and capability" and that currently services do not have the staff they need.

Objective four is to grow the workforce, and asks trusts to:

- Undertake regular local workforce planning, and to meet staffing establishment levels set by Birthrate Plus by 2027/28
- Develop and implement local plans to fill vacancies, including specific support for newly qualified staff and returners
- Provide additional administrative support.

ICBs are asked to commission and fund safe staffing levels, agreed with trusts, and NHS England commits to:

- Increasing midwifery workforce supply across multiple routes
- Increasing medical training places across obstetrics and gynaecology and anaesthetics
- Working with RCOG to develop a workforce planning tool for obstetrics.

Objective five is to retain the workforce, and asks trusts to take several actions in support:

- Develop a retention improvement action plan to address local retention issues
- Reduce workforce inequalities and create an anti-racist workplace by acting on principles set out in combatting racial discrimination resources
- Identifying and addressing issues highlighted in student and trainee feedback surveys
- Offering newly registered midwives a preceptorship programme and providing mentors for newly appointed band 7 and 8 midwives
- Carry out succession planning and ensuring that the leadership pipeline represents the ethnic background of the workforce.

NHS England commits to several actions, including:

- Providing funding for a retention midwife in every maternity unit during 2023/24, with ICBs providing this thereafter
- Providing funding to establish neonatal nurse quality and governance roles in trusts
- Strengthening neonatal clinical leadership at the national level.

Objective six is to **invest in skills** and asks trusts to:

- Undertake an annual training needs analysis and make training available in line with the core competency framework
- Ensure obstetricians and neonatal medical staff have appropriate clinical supervision in line with RCOG and British Association of Perinatal Medicine (BAPM) guidance
- Ensure locum medical staff covering middle grade obstetric rotas for two weeks or less possess an RCOG certificate of eligibility.

NHS England's proposed actions include:

- Refreshing the curriculum for maternity support workers and supporting the implementation of the maternity support worker (MSW) competency, education and career development framework
- Developing leadership role descriptors for obstetricians by summer 2023
- Establishing a national training route for obstetric physicians.

Progress against these objectives will be measured by national surveys including the NHS Staff Survey and the GMC training survey, along with workforce data.

Theme 3: Developing and sustaining a culture of safety, learning and support

This theme focuses on cultural issues identified in the Kirkup report including teamworking, professionalism, compassion, listening, and learning. It sets out objectives related to developing a safety culture, learning and improving, and support and oversight.

Objective seven relates to **developing a positive safety culture**, and sets an ambition that all staff working in maternity and neonatal services:

- Are supported to work with professionalism, kindness, compassion, and respect
- Are psychologically safe to voice their thoughts and are open to constructive challenge
- Receive constructive appraisals and support with their development

- Work, learn and train together as a multi-disciplinary team.

The objective sets out a number of actions for trusts:

- Ensuring maternity and neonatal leads have the time, training and development and lines of accountability to focus on developing a safety culture
- Supporting senior leaders to engage in national leadership programmes offered by NHS England by April 2024
- At board level, reviewing an implementation plan to improve and sustain culture, aligned with freedom to speak up (FTSU)
- Ensuring staff are supported by clear and structured routes for the escalation of clinical concerns
- Ensuring staff have access to FTSU training modules and a Guardian who can support them to speak up.

Objective eight relates to **learning and improving** and sets an ambition that services will respond effectively when safety incidents occur. It requires trusts to:

- Establish and maintain effective and compassionate processes to respond to families who experience harm or raise concerns, in line with the principles of duty of candour and including a single point of contact
- Respond effectively and openly to patient safety incidents using the patient safety incident response framework (PSIRF)
- Acting on outcomes data, staff feedback, clinical audits and other sources of information to learn from where things do not go well, as well as understanding 'what good looks like'
- Giving adequate time and formal structures to review and share learning and implement resulting actions
- Consider culture, ethnicity and language factors when responding to incidents.

Objective nine relates to **support and oversight** and sets out how trusts and ICBs should ensure good oversight of their maternity and neonatal services, with clear escalation processes. For example, trusts are asked to:

- Regularly review the quality of maternity and neonatal services, supported by the perinatal quality surveillance model and national maternity dashboard at a minimum
- Appointing an executive and non-executive maternity and neonatal board safety champion
- Involving the maternity and neonatal voice partnership in developing the trust's complaints process
- Listen to and act on feedback from staff at board level, in line with FTSU guidance.

NHS England acknowledges that it is difficult to measure cultural improvement, and therefore will focus on the feedback of frontline staff as recorded by the NHS Staff Survey and other national surveys.

Theme 4: Standards and structures that underpin safer, more personalised and more equitable care

This theme acknowledges the need to develop clear standards and structures to support the delivery of the plan, including clinical best practice, the provision of high-quality data, and effective digital tools. The plan stresses that the plan does not create additional standards but seeks the consistent adoption of existing standards.

Objective ten relates to best practice. It asks for trusts to:

- Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025, which will be updated by NHS England
- Regularly review and act on key local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality
- Ensure staff are enabled to deliver care in line with evidence-based guidelines including NICE
- Complete the national maternity self-assessment tool and use the findings to inform improvement plans.

As well as developing new best practice, NHS England commits to:

- Supporting the integration of MEWS, NEWTT-2 and other tools with existing digital maternity information systems by autumn 2024
- Providing support to capital projects to increase and align neonatal cot capacity in 2023/24 and 2024/25
- Conducting a national maternity and neonatal infrastructure compliance survey to determine the level of investment needed for the maternity and neonatal estate.

Objective eleven relates to using data and asks for trusts to:

- Review available data to identify and address areas of concern in maternity services, including inequalities
- Ensuring high-quality submissions to the maternity services data set and report incidents as appropriate to NHS Resolution, Healthcare Safety Investigation Branch (HSIB) and the national perinatal epidemiology unit.

NHS England commits to several actions including convening a taskforce to progress the Kirkup report recommendation for a maternity and neonatal early warning system, to report by autumn 2023.

Objective twelve relates to **using digital technology in maternity and neonatal services.** It asks for trusts to:

- Develop and begin implementation of a digital maternity strategy and roadmap in line with NHS England's framework
- Where not being managed by the ICB, procure an EPR which complies with national specifications, including the digital maternity record standard and maternity services data set
- Include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set in neonatal module specifications.

NHS England sets out several supporting actions including:

- Setting out the specification for a complaint EPR, including maternity, by March 2024
- Publishing a refreshed digital maternity record standard and maternity services data set standard by March 2024
- Incorporating pregnancy-related data and features into the NHS App.

Success measures for this theme include existing key outcome measures for safety: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after births, and preterm births – monitored nationally by ethnicity and deprivation.

NHS England will also use other metrics including the local implementation of version 3 of the Saving Babies' Lives Care Bundle and periodic digital maturity assessments of trusts.

All of the above themes will also be considered by CQC as part of their inspection criteria.

NHS Providers view

This plan is a welcome rationalisation of important recommendations to improve the safety and quality of maternity services, providing a clear sense of priorities for the next three years.

There are a number of important asks of trusts within this plan. Some trusts will already be delivering many of them, but all trusts should review the asks and identify any additional actions that may be

required. Trust boards should pay particular attention to theme 3, creating a positive safety culture in maternity and neonatal services, which contains several actions to be taken forward at board level.

The plan also rightly acknowledges that the implementation of these asks will not be possible without supporting factors such as sufficient workforce, appropriate capital investment, and progress on digital technology. NHS England sets out its own responsibilities in this report as well as the responsibilities of ICBs – this level of clarity over ownership is welcome. However, it is important that regulation of trusts against this plan, including within CQC inspection criteria, takes into consideration the enabling actions required by NHS England and ICBs.